Your Right to Appeal

Ensuring the right to appeal health plan decisions

The Patient Protection and Affordable Care Act (Affordable Care Act) offers you several new protections. This fact sheet explains that consumers have the right to appeal health plan decisions, an important way that those with private insurance can protect their coverage.

Before the Affordable Care Act was passed, people's rights to appeal decisions made by their health plans varied depending on where they lived, what type of health plan they had, and whether they bought insurance themselves or got it through their job. In some states, when people disagreed with their health plan's decision, they could appeal that decision outside of their health plan, and in other states, they had no appeal rights.

The new law changes this. Under the Affordable Care Act, if you disagree with your plan's refusal to pay for care, the plan will have to review its decision. And if you still are not satisfied, you will have the right to appeal that decision to an independent reviewer who is outside of the health plan.

These protections apply to you if, after March 23, 2010, (1) you buy a new individual or family health plan in the individual market, or (2) your employer did not previously offer coverage and buys a new health plan to cover you and other employees. They also apply if you have coverage through your job and, since March 23, 2010, (1) your plan has significantly cut the benefits it covers, (2) your plan has substantially increased the amount you must pay in cost-sharing or deductibles, or (3) your employer has decreased the amount it pays toward your premiums by more than 5 percent. (For more information, see the Families USA fact sheet, *Grandfathered Plans under the Patient Protection and Affordable Care Act*, available online at http://www.familiesusa.org/assets/pdfs/health-reform/Grandfathered-Plans.pdf.)

These new rights are important: Eventually, they are expected to cover 88 million people. And research shows that consumers who do appeal outside of their insurance companies win their cases about 45 percent of the time.[1]

If it appears that your plan will not be subject to the new protections, check with your state insurance department, your employer, and your health plan to find out whether you have similar appeal rights.

The Kinds of Decisions You Can Appeal

You can appeal a plan's decision not to pay for a benefit, or to reduce or end a covered service, when the plan says any of the following: (1) the care is not medically necessary or appropriate, (2) you are not eligible for the health plan or benefit, (3) you have a pre-existing condition, or (4) the care is experimental or investigational. If the plan has told you any of these things and you disagree, you can appeal. You can also appeal when the plan rescinds your coverage (cancels your coverage retroactively). The plan must give you a notice when it denies payment or rescinds your coverage that explains both the reason and how to appeal.

When the New Appeal Rights Go into Effect

States, the federal government, and health plans are all putting the new appeal system in place over the coming year. It will be fully operational for plan years beginning after July 2011, but health plans and states are already starting to make improvements to their appeals processes.

The Appeal Process

First, ask for an "internal review."

You should receive a notice from your plan with instructions about how to request a review and the deadline for doing so.

- Other people in the health plan who were not involved in the plan's original decision will review the case. They must consult with appropriate medical experts.
- You have a right to get the details of why the plan refused to pay for your care. You can review the plan's file about your case, get the medical evidence the plan used, and get the plan's guidelines about when it does and doesn't pay for the type of care you requested. The plan cannot charge you for this information.
- You have a right to present testimony and more evidence for the plan to consider. You can respond to any evidence the plan uses. For example, you might want to submit letters from your doctors and information from medical journals about why a benefit is appropriate. Or, if the plan is rescinding coverage, you may want to submit testimony and evidence that any errors you made on your insurance application were unintentional, honest mistakes.
- You can ask a consumer assistance program or another representative of your choosing to help you.
- If you want, you can ask the plan to continue paying for your treatment until the appeal has been decided.

- The plan must expedite the review if the matter is urgent and you ask them to do so. For example, if your health would be in serious jeopardy or you would experience severe pain, the plan must conduct its review and make a decision within 24 hours, or sooner if necessary. If the matter is urgent, you can also request an "external appeal" from an independent reviewer immediately, at the same time that you ask for an internal review. You don't have to wait for the plan's internal review decision.
- When the plan finishes its internal review, it must give you a notice of its final decision and the reasons for it, and the notice must explain how you can appeal outside of the plan to an external, independent reviewer.

Second, if you are not satisfied with the decision or the matter is urgent, appeal to an independent reviewer who is not part of the health plan. This is called an "external appeal."

- The notice you get from your plan should explain where to send your appeal request. For example, state insurance departments or health departments might handle appeal requests for some types of plans, and private, independent review organizations might directly handle appeals for other types of plans. In any case, these reviewers must be independent of the health plan and have no conflicts of interest—they must be able to make a fair and impartial decision.
- You have some time to gather evidence before you submit your appeal. After you receive the plan's internal review decision, you have at least four months to request an external review. (Of course, if you need treatment quickly, you will want to appeal much sooner.) This gives you some time to gather doctor statements, medical literature, and other evidence that you might want to submit with your request for an appeal.
- After you have submitted your request for an appeal, you will receive notice that you have another five business days to submit any additional information that you want considered. If the plan submits new evidence or information, you will have an opportunity to respond.
- The independent reviewer will make a decision within 45 days, but you can ask for an expedited review if the matter is urgent. In that case, the reviewer will decide on your case within 72 hours, or even sooner if necessary.
- The plan must follow the reviewer's decision. If the independent reviewer decides that the plan should cover your treatment, the plan must do so. The only time that the plan can continue to refuse payment is if the plan takes the matter to court.

You Can Get Help with Your Appeal from a Consumer Assistance Program

Many states are establishing consumer assistance programs to help consumers with appeals and to help them understand their health insurance rights. Notices from your insurer should give you contact information for the consumer assistance program in your state. You can also ask your state insurance department if there is a consumer assistance program, or you might be able to find a knowledgeable advocate to help you with your appeal by contacting a legal services program, your state bar association, or a disease association for people with your illness. If you are in a job-based plan, you can also get help through the U.S. Department of Labor's Employee Benefits Advisors by calling 1-866-444-EBSA (3272).

For More Information

For more information, see the following resources:

- U.S. Department of Labor website at www.dol.gov/ebsa
- U.S. Department of Labor's benefit advisors, who can be reached by calling 1-866-444-EBSA (3272)
- The government's new health care website at www.healthcare.gov
- Your state insurance department
- A consumer assistance program. Families USA lists some consumer assistance programs online at http://www.familiesusa.org/resources/program-locator/. An updated list may also be posted on www.healthcare.gov

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[1] Kaiser Family Foundation, *Assessing State External Review Programs and the Effects of Pending Federal Patients' Rights Legislation* (Washington: Kaiser Family Foundation, 2002), available online at http://www.kff.org/insurance/externalreviewpart2rev.pdf; U.S. Department of Labor, *The Affordable Care Act: Protecting Consumers and Putting Patients Back in Charge of Their Care*, July 22, 201, available online at www.dol.gov/ebsa/newsroom/fsaffordablecareact.html.

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